



# Sleep Center Evaluation

Have you ever had an evaluation at a Sleep Center?  Yes  No

If Yes:

Sleep Center Name \_\_\_\_\_  
and Location \_\_\_\_\_

Sleep Study Date \_\_\_\_\_

## FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of:  *mild*  
 *moderate* obstructive sleep apnea  
 *severe*

The evaluation showed an RDI of \_\_\_\_\_ and an AHI of \_\_\_\_\_

## CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed or interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: \_\_\_\_\_

## Other Therapy Attempts

What other therapies have you had for breathing disorders?  
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

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Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## List any medications which have caused an allergic reaction:

- |   |  |                        |
|---|--|------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics       | <input type="checkbox"/> Y <input type="checkbox"/> N Metals         | Other allergens: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin           | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin     | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates      | <input type="checkbox"/> Y <input type="checkbox"/> N Plastic        | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine           | <input type="checkbox"/> Y <input type="checkbox"/> N Sedatives      | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Iodine            | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Latex             | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs    | _____                  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Local anesthetics |  |                        |

## List any medications you are currently taking:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Antacids                                 | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine                        | <input type="checkbox"/> Y <input type="checkbox"/> N Pain medication |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antibiotics                              | <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone                      | <input type="checkbox"/> Y <input type="checkbox"/> N Sleeping pills  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anticoagulants                           | <input type="checkbox"/> Y <input type="checkbox"/> N Diet pills                     | <input type="checkbox"/> Y <input type="checkbox"/> N Sulfa drugs     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Antidepressants                          | <input type="checkbox"/> Y <input type="checkbox"/> N Heart medication               | <input type="checkbox"/> Y <input type="checkbox"/> N Tranquilizers   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anti-inflammatory drugs<br>(non-steroid) | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure medication |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates                             | <input type="checkbox"/> Y <input type="checkbox"/> N Insulin                        | Other current medications: _____                                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood thinners                           | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle relaxants               | _____   |
|  | <input type="checkbox"/> Y <input type="checkbox"/> N Nerve pills                    | _____   |

## Medical History

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart pacemaker  | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis                      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis  | <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve replacement  | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis                        |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma  | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn or a sour taste<br>in the mouth at night                       | <input type="checkbox"/> Y <input type="checkbox"/> N Poor circulation                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders                                      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis  | <input type="checkbox"/> Y <input type="checkbox"/> N Prior orthodontic treatment         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding easily   | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure  | <input type="checkbox"/> Y <input type="checkbox"/> N Recent excessive weight<br>gain     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic sinus problems                                    | <input type="checkbox"/> Y <input type="checkbox"/> N Immune system disorder   | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever                     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic fatigue   | <input type="checkbox"/> Y <input type="checkbox"/> N Injury to<br><input type="checkbox"/> Face <input type="checkbox"/> Neck | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath                 |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia   | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen, stiff or painful<br>joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Current pregnancy   | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat   | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems                    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes  | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw joint surgery  | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillectomy (have had)            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty concentrating                                  | <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure   | <input type="checkbox"/> Y <input type="checkbox"/> N Wisdom teeth extraction             |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness   | <input type="checkbox"/> Y <input type="checkbox"/> N Memory loss  | Other medical history:<br>_____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema   | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines  | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy  | <input type="checkbox"/> Y <input type="checkbox"/> N Morning dry mouth  | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia  | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle spasms or<br>cramps   | _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent sore throats                                     | <input type="checkbox"/> Y <input type="checkbox"/> N Needing extra pillows to<br>help breathing at night                      |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastroesophageal Reflux<br>Disease (GERD)                 | <input type="checkbox"/> Y <input type="checkbox"/> N Nighttime sweating   |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever   |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart disorder  |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur  |  |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart pounding or beating<br>irregularly during the night |  |   |

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# Berlin Questionnaire Sleep Evaluation

1. Complete the following:

height \_\_\_\_\_ age \_\_\_\_\_

weight \_\_\_\_\_ male/female \_\_\_\_\_

2. Do you snore?

- yes  
 no  
 don't know

**If you snore:**

3. Your snoring is?

- slightly louder than breathing  
 as loud as talking  
 louder than talking  
 very loud. Can be heard in adjacent rooms

4. How often do you snore?

- nearly every day  
 3-4 times a week  
 1-2 times a week  
 1-2 times a month  
 never or nearly never

5. Has your snoring ever bothered other people?

- yes  
 no

6. Has anyone noticed that you quit breathing during your sleep?

- nearly every day  
 3-4 times a week  
 1-2 times a week  
 1-2 times a month  
 never or nearly never

7. How often do you feel tired or fatigued after your sleep?

- nearly every day  
 3-4 times a week  
 1-2 times a week  
 1-2 times a month  
 never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- nearly every day  
 3-4 times a week  
 1-2 times a week  
 1-2 times a month  
 never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- yes  
 no

If yes, how often does it occur?

- nearly every day  
 3-4 times a week  
 1-2 times a week  
 1-2 times a month  
 never or nearly never

10. Do you have high blood pressure?

- yes  
 no  
 don't know

(For office use)

Scoring Questions: Any answer within the box outline is a positive response

Scoring categories:

Category 1 is positive with 2 or more positive responses to questions 2-6

Category 2 is positive with 2 or more positive responses to questions 7-9

Category 3 is positive with 1 positive response and/or a BMI > 30

(BMI = Body Mass Index)

Final Result: 2 or more possible categories indicates a high likelihood of sleep disordered breathing.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Berlin

# THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✓ Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total Score: \_\_\_\_\_

*(Add columns 0-3)*

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_